DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/19/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G007	A. BUILDING ______ B. WING ______	C 07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND VILLAGE	S 2320 SALNAVE RD, PO BOX 200 MEDICAL LAKE, WA 99022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS This report is the result of complaint surveys at Lakeland Village on 06/10/19, 06/14/19, 07/08/19, and 07/09/19 for complaint #3655524, #3653670, #3649493, #3648862, and #3648811. Deficient practice was identified and citations were written. These surveys were conducted by: Patrice Perry The survey team is from: Department of Social & Health Services Aging & Long Term Support Administration Residential Care Services, ICF/IID Survey and Certification Program PO Box 45600, MS: 45600 Olympia, WA 98504 Telephone: (360) 725-3215	W 000	POC ON SEPARATE DOCUMENT RECEIVED AUG 02 2019 Residential Care Services ICF/IID Program	
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to protect the rights of one of five sample Clients (Client #3) when they altered his diet texture without attempting less restrictive measures first. This failure resulted in Client #3 having an altered diet without training to reduce any potential risks.	W 125		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Superintendent
(X6) DATE: 8-2-19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G007	A. BUILDING _____ B. WING _____	C 07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND VILLAGE	S 2320 SALNAVE RD, PO BOX 200 MEDICAL LAKE, WA 99022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 125	Continued From page 1 Findings included ... Record review of facility incident report (IR) #15849, dated 05/20/19, showed that Client #3 stole two packages of cookies from a peer and ate them in the bathroom. Record review of Client #3's diet order, dated 05/20/19, showed his diet was dysphagia mechanically altered, described as " ...soft and moist with added liquid fully mixed into food, food chopped to approximately 1/8 inch by 1/8 inch ..." Record review of Client #3's Speech-Language Assessment, dated 02/28/17, showed Client #3 had a Modified Barium Swallow (MBS) on 11/20/17. The MBS showed he had functional chewing and swallowing ability of all solid foods, with no sign of aspiration (when food or fluid enters the lungs potentially causing pneumonia). The speech assessment identified that Client #3 tended to take large bites and did not chew his food thoroughly. Staff were to alter his diet into small, bite size pieces and monitor how quickly he ate. There was no indication that the facility developed a plan to reduce the diet restriction for Client #3. During an interview on 07/09/19 at 8:11 AM, Staff A, Assistant Superintendent, and Staff B, Quality Assurance Director, stated that the facility prescribed Clients #3's diet based on the Speech-Language assessment and they were unsure if Client #3 required training related to eating too quickly.	W 125		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1)	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G007	A. BUILDING _____ B. WING _____	C 07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND VILLAGE	S 2320 SALNAVE RD, PO BOX 200 MEDICAL LAKE, WA 99022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 2 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure full implementation of their investigatory process of allegations of abuse, neglect, and misappropriation/theft, for one of five facility investigations (#15849). This failure resulted in an allegation of theft not being investigated, leaving all Clients at risk for potential harm by having incomplete investigations into allegations. Findings included ... Record review of Residential Care Services Intake #3648862 showed the facility reported that Client #3 stole cookies from Client #2's purse. Record review of facility incident report #15849, dated 05/20/19, showed that the facility did not address the theft of Client #2's belongings or if she had a negative impact related to the theft and loss of privacy when Client #3 took items from her purse. Record review of Client #2's Interdisciplinary Progress Notes, dated 05/16/19-06/10/19, showed no documentation regarding her emotional state after another Client stole cookies from her purse. During an interview on 07/09/19 at 8:11 AM, Staff B, Assistant Superintendent, stated that the facility did not investigate the incident as an allegation of theft.	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G007	A. BUILDING _____ B. WING _____	C 07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND VILLAGE	S 2320 SALNAVE RD, PO BOX 200 MEDICAL LAKE, WA 99022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to complete thorough investigations for three of five (incident reports #15849, #01-05202019, and #02-5242019) facility incidents. This failure prevented the facility from knowing all aspects of the incidents, which prevented them from developing comprehensive responses to the incidents. Findings included ... 1. Root cause of incident not identified Record review of facility incident report (IR) #01-05202019, dated 05/20/19, showed that the facility investigation determined that Staff E, Attendant Counselor, did not follow the required supervision level for Client #1. The IR identified that Client #1 was in a sex offender treatment program and had specific limitations related to what magazines they could review, how close to other people they could be, and how close staff should be when Client #1 was out of the cottage in order to prevent Client #1 from inappropriately touching other people. The IR did not indicate why the accused staff member did not follow the plan of care for Client #1. The IR did not include evidence that all staff were implementing the plan of care for Client #1 appropriately. During an interview on 07/09/19 at 8:22 AM, Staff B, Assistant Superintendent, and Staff C, Quality Assurance Director, stated that the facility did not	W 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G007	A. BUILDING _____ B. WING _____	C 07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND VILLAGE	S 2320 SALNAVE RD, PO BOX 200 MEDICAL LAKE, WA 99022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 154	Continued From page 4 look at whether there were problems with other staff implementing the plan for supervision of Client #1. They also stated that the facility was not monitoring staff related to Client #1's supervision needs, to ensure they followed the plan of care. 2. Theft not investigated Record review of Residential Care Services Intake #3648862 showed the facility reported Client #3 stole cookies from Client #2's purse. Record review of the facility incident report (IR) #15849, dated 05/20/19, showed that the facility did not investigate this incident from the aspect of Client #2 having her belongings stolen. During an interview on 07/09/19 at 8:11 AM, Staff B, Assistant Superintendent, and Staff C, Quality Assurance Director, stated that the facility did not investigate the incident as theft. During an interview on 07/09/19 at 8:58 AM, Staff A, Adult Programs Supervisor, stated that he completed the investigation related to the theft of the cookies and the focus of the investigation was whether Client #3 had a negative impact on his health from eating food out of his prescribed diet texture. He did not identify the theft from Client #2 as a concern requiring investigation because Client #3 had a known history of stealing. 3. No identification of where Client #3 got money Record review of the facility IR #15849, dated 05/20/19, showed Client #3 took cookies out of Client #2's purse while at Adult Programs. It did not identify if cookies were the only thing potentially stolen from the purse.	W 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G007	A. BUILDING _____ B. WING _____	C 07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND VILLAGE	S 2320 SALNAVE RD, PO BOX 200 MEDICAL LAKE, WA 99022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 154	Continued From page 5 Record review of Client #3's Interdisciplinary Notes, dated 05/20/19, showed an entry after he returned from Adult Programs and it identified that Client #3 had $1.35 and the cottage staff did not know where he got it. Observation at Chappies store on 06/14/19 at 9:30 AM showed Client #2 sat in her wheelchair with her purse on the right side of her body. When asked if Client #2 had money she pulled a small yellow envelope out of her purse. When asked if she had a wallet she nodded and pointed to her purse. During an interview on 07/09/19 at 8:58 AM, Staff A, Adult Programs Supervisor, stated that they were not aware that Client #3 had money on the same day that Client #3 took the cookies from Client #2's purse, and that they had not included the potential for other items being stolen as part of their investigation. 4. No resolution of discrepancies A. Identification of the Alleged Perpetrator (AP) Record review of facility investigation #02-5242019, dated 05/24/19, showed Client #4 alleged that a staff member had touched her butt. Client #4 reported the staff initials were "DA". The facility identified the AP as Staff F, Attendant Counselor, whose initials were not DA. The investigation did not identify how the facility determined the AP was Staff F and not a staff member with the initials DA. During an interview on 07/09/19 at 9:31 AM, Staff G, Statewide Investigation Unit Investigator	W 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G007	A. BUILDING _____ B. WING _____	C 07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND VILLAGE	S 2320 SALNAVE RD, PO BOX 200 MEDICAL LAKE, WA 99022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 154	Continued From page 6 (SIUI), stated that they determined who the AP was through staff interviews. They also stated that the investigation did not identify that Staff F, AC, went by the initials DA and it should have been included in the investigation. B. Client #4 touching staff on the butt Record review of facility investigation #02-524019, dated 05/24/19, showed the initial witness statement that reported the allegation. It stated "Client told me at about 1815 [6:15PM] that a day shift AC staff said for [Client #4's first name] to stop touching the staff member's butt." The witness statement also identified that Client #4 reported that a day shift AC touched Client #4 on the butt. During an interview on 07/09/19 at 9:31 AM, Staff G, SIUI, stated that Client #4 touching staff on the butt was not the focus of the investigation and the investigation did not address the issue.	W 154		
W 155	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to implement immediate, appropriate protective measures when one of five Sample Clients (Client #5) alleged a sexual relationship with a staff member. This failure placed Clients at risk for further abuse by the Alleged Perpetrator (AP).	W 155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G007	A. BUILDING _____ B. WING _____	C 07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND VILLAGE	S 2320 SALNAVE RD, PO BOX 200 MEDICAL LAKE, WA 99022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 155	Continued From page 7 Findings included ... Record review of facility incident report 01-06242019, dated 06/24/19, showed Client #5 reported a sexual relationship with the AP, Staff H, Attendant Counselor. The incident report identified that the facility sent the AP to work at a different cottage, away from the Alleged Victim, on the date of the sexual abuse allegation. The facility placed the AP on alternate assignment, away from Clients, on 06/25/19, one day after the allegation. During an interview on 07/09/19 at 7:45 AM, Staff B, Assistant Superintendent, stated that the facility did not remove the AP from care of Clients on the day they learned of the allegation.	W 155		
W 156	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4) The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to complete an investigation of alleged sexual abuse within five days for one of five Sample Clients (Client #5). This failure potentially prevented the facility from identifying supports for the Client and to prevent potential recurrence of the alleged incident. Findings included ...	W 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G007	A. BUILDING _____ B. WING _____	C 07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND VILLAGE	S 2320 SALNAVE RD, PO BOX 200 MEDICAL LAKE, WA 99022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 156	Continued From page 8 Record review on 07/09/19 of facility incident report #01-06242019, dated 06/24/19, showed Client #5 reported a sexual relationship with a staff member. The facility had not completed the investigation. During an interview on 07/09/19 at 7:45 AM, Staff B, Assistant Superintendent, stated that the facility did not complete an investigation within the 5-day timeline due to law enforcement investigating it as a criminal case.	W 156		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop objectives related to one of five Sample Clients (Client #4) false allegations against staff. This failure prevented Client #4 from learning how to make her wants/needs known in a constructive way. Findings included ... Record review of facility incident report #02-5242019, dated 05/24/19, showed Client #4 reported that Staff F, Attendant Counselor, "touched her butt." The investigation identified that the facility knew that Client #4 expressed anxiety and was reluctant to work with staff when she had difficulty understanding their speech, and	W 227		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G007	A. BUILDING _____ B. WING _____	C 07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND VILLAGE	S 2320 SALNAVE RD, PO BOX 200 MEDICAL LAKE, WA 99022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 227	Continued From page 9 had made prior false allegations about staff, to avoid having them care for her. The investigation also identified that Staff F spoke English as a second language and Client #4 had difficulty understanding Staff F when they spoke. The investigation included the statement "Resident [Client #4's last name] difficulty working with individuals she struggles to understand should be addressed in her plan." During an interview on 07/09/19 at 8:10 AM, Staff B, Assistant Superintendent, stated that the facility was developing a communication program for Client #4 related to her difficulty understanding some staff that spoke English as a second language. Record review of an untitled, undated document, received from the facility on 07/15/19, showed that Staff J, Psychology Associate, met with Client #4, would develop social intervention stories, and then set up training for "8 ways to deal with people you don't like."	W 227		
W 239	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(5)(vi) Each written training program designed to implement the objectives in the individual program plan must specify provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to identify a replacement behavior for one	W 239		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G007	A. BUILDING _____ B. WING _____	C 07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND VILLAGE	S 2320 SALNAVE RD, PO BOX 200 MEDICAL LAKE, WA 99022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 239	Continued From page 10 of five Sample Clients (Client #3). This failure prevented Client #5 from learning how to obtain items he wanted without stealing them. Findings included ... Record review of facility incident report #15849, dated 05/20/19, showed Client #3 stole cookies from a Client's purse while in Adult Programs (AP). Record review of Client #3's Interdisciplinary Progress Notes, dated 05/20/19, showed he had money in his pocket after returning from AP and no one knew where it came from. Record review of Client #3's Individual Habilitation Plan, dated 04/10/19, showed a history of Client #3 stealing food and money to obtain food from a vending machine. Record review of Client #3's Functional Assessment and Positive Behavior Support Plan (PBSP), dated 04/10/19, showed that staff should have Client #3 return money or items that he had stolen. The PBSP did not include any replacement behaviors to teach Client #3 how to obtain items he wanted, instead of stealing food or money from others. During an interview on 07/09/19 at 8:11 AM, Staff B, Assistant Superintendent, and Staff C, Quality Assurance Director, stated that the current PBSP reinforced the behavior of stealing.	W 239		

Intermediate Care Facility: Lakeland Village
POC for SOD Date 07-09-2019 and Aspen Event ID# JXC911

Tag number

W-125

CFR and title

§483.420(a)(3) PROTECTION OF CLIENTS RIGHTS

Specific language from CFR

The facility must ensure the rights of all clients. Therefore the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the Unites States, including the right to file complaints, and the right to due process.

Explain the process that lead to this deficiency.

The facility has not historically considered altered diet textures to be restrictive. This resulted in some diet textures being implemented without following due process. Also, this resulted in inconsistent expectations with regards to reduction plans to reduce the need for the dietary restriction.

The plan correcting the specific deficiency.

1. Client #3's diet order went through the informed consent process and was consented to by the guardian on 2-1-19 and reviewed by the Lakeland's Human Rights Committee (HRC) on 2-25-19.
   Person(s) Responsible: [redacted] Habilitation Plan Administrator (HPA)
   Completed by: 2-25-19
2. Client #3's IDT will develop a formal training program to teach him how to become more independent at pacing himself when eating his food.
   Person(s) Responsible: [redacted] Speech Language Pathologist (SLP); [redacted] HPA; [redacted] Attendant Counselor Manager (ACM); 82/83 Sunrise IDT
   Completed by: 8-5-19
3. Client #3's formal program to become more independent at eating will be implemented.
   Person(s) Responsible: [redacted] HPA
   Completed by: 8-6-19

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. All Lakeland Village IDTs are reviewing all diet orders to determine if the order is restrictive.
   Person(s) Responsible: Cottage IDTs
   Completed by: 8-1-19
2. DSHS Form 17-242, Residential Habilitation Center (RHC) Informed Consent will be completed for all diet orders that have been reviewed and contain restrictive components.
   Person(s) Responsible: Cottage IDTs
   Completed by: 8-15-19
3. Diet orders that contain restrictive elements will be evaluated to determine if corresponding support and training would meet the resident's need in place of the restrictive element. Diet orders were modified in those circumstances and appropriate supports and training programs (formal or informal) developed.
   Person(s) Responsible: Cottage IDTs
   Completed: 8-23-19
4. All diet orders with restrictive components and associated DSHS Form 17-242, RHC Informed Consent will go through due process, including guardian consent and HRC review.
   Person(s) Responsible: Cottage IDTs
   Completed by: 8-30-19
5. All Lakeland Village ICF IDT members received training on what constitutes a support vs a restriction.
   Person(s) Responsible: [redacted] Quality Assurance Director (QAD)
   Completed on: 7-15-19
6. All Lakeland Village ICF IDT members received training on reduction plan for restrictive elements of a residents Individual Habilitation plan.
   Person(s) Responsible: [redacted] QAD
   Completed by 7-15-19
7. All Lakeland Village ICF IDT members received training on what is required to complete DSHS Form 17-242, RHC Informed Consent.
   Person(s) Responsible: [redacted] QAD

Superintendent	[signature]	8-2-19
Title	Signature	Date

Completed by: 7-24-19

8. Disciplines who recommend restrictive elements to a residents IHP are now responsible for completing DSHS Form 17-242. Once completed the restriction will be reviewed by the HPA and IDT. Necessary associated training programs, either formal or informal, will be discussed and developed with the IDT. Due process will be followed for every restrictive element of a resident's IHP.
   Person(s) Responsible: Cottage IDTs
   Completed by: 7-17-19

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

1. Completed reviews of all diet orders will be routed to the Quality Assurance Department. The Quality Assurance Department will verify all diet orders have gone through appropriate due process. The Quality Assurance Department will also verify appropriate reduction plans and required training components are developed as required.
2. The Quality Assurance Department will review all diet order changes for the next 60 days. This review will include verifying due process is followed for changes that include restrictive elements as well as verifying required reduction plans and training programs are developed.
3. The Quality Assurance Department will then review a 25% sample of all diet orders quarterly to verify appropriate reduction plans, required training, and due process is followed as required.
4. HPAs will receive a notification of all diet order changes. HPAs will review diet order changes to verify due process is followed as required.
5. Dietitians will report resident's progress, at least quarterly, on gaining more independence and not needing the restrictive element of the diet order, or why the restrictive element should be continued.

The title of the person or persons responsible for implementing the acceptable plan of correction

[redacted]QAD

Dates when the corrective action will be completed.

Lakeland Village will accomplish the corrective actions by September 6th, 2019.

Tag number

W-149

CFR and title

§483.420(d)(1) STAFF TREATMENT OF CLIENTS

Specific language from CFR

The facility must develop and implement written policies and procedures that prohibit the mistreatment, neglect or abuse of the client.

Explain the process that lead to this deficiency.

The facility does not currently have an employee dedicated to incident management. The absence of this position has resulted in multiple employees reviewing incidents and investigations at different stages as well as inconsistent expectations of what investigations should cover.

The plan correcting the specific deficiency.

1. The facility completed further investigation for incident #15849 and was unable to determine the source of where Client #3 obtained the money. It was possible for Client #3 to have obtained the money from a number of possible sources.
2. Client #3's IDT has met on 7-18-19 and reviewed incident #15849. The IDT will develop a formal program to address Client #3's behavior of stealing, including teaching Client #3 the consequences of stealing.
   Person(s) Responsible: [redacted](HPA)
   Completed 8-9-19

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. A Position Description Form (PDF) for an Incident Management Coordinator has been developed and reviewed by Class and Compensation. This position will be responsible for reviewing and providing investigatory feedback for every incident that occurs on Lakeland Village ICF. This position will also be responsible for:

a. Reviewing completed investigations to verify the investigation was thorough and addresses compliance with local work procedures, DDA Policy, and Codes of Federal Regulation for the ICF
b. Verifies investigations identify and investigate the root cause of why the incident occurred,
c. Verifies any discrepancies identified in an investigation are resolved,
d. Necessary and required client protections were in place to prevent further potential abuse during the incident investigation process,
e. Corrective Action Plans developed during investigations meet the needs of the residents identified,
f. All corrective action plans identified are completed within identified timelines, and
g. All investigations are completed within 5 days of incident occurrence.
h. Provides immediate feedback and training to facility investigators for deficiencies identified during incident report and investigation reviews.

Person(s) Responsible: [redacted] QAD
Completed by: 7-25-19

2. The Quality Assurance Director initiated working with the Department of Social and Health Services to create a recruitment notice to attract qualified candidates for the position.
   Person(s) Responsible: [redacted] QAD
   Completed by: 7-26-19
3. Interviews will be conducted with all qualified candidates.
   Person(s) Responsible: [redacted] QAD
   Completed by: 8-15-19
4. The preferred candidate from the interview process will be properly vetted following DSHS standards and an offer will be made as applicable. Should an appropriate candidate not be revealed through these processes the Quality Assurance Director will work with DSHS Talent Management to reopen the recruitment notice.
   Person(s) Responsible: [redacted] QAD
   Completed by: 9-6-19

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

1. The Quality Assurance Department will continue regular reviews of a sample of incident reports and corresponding investigations to verify thoroughness and timeliness of investigations.
2. Once hired, the Incident Management Coordinator will review and provide guidance and feedback to all incident investigations that occur at Lakeland Village ICF. The feedback and guidance will be provided within in 1 business day of an incident occurring and throughout the investigative process to verify each investigation is thoroughly completed. This position will also be responsible for facilitating regularly scheduled meetings, at least quarterly, with incident management personnel to review systematic deficiencies or best practices

The title of the person or persons responsible for implementing the acceptable plan of correction

[redacted] QAD

Dates when the corrective action will be completed.

Lakeland Village will accomplish the corrective actions by September 6th, 2019.

Tag number

W-154

CFR and title

§483.420(d)(3)

Specific language from CFR

The facility must have evidence that all alleged violations are thoroughly investigated.

Explain the process that lead to this deficiency.

The facility does not currently have an employee dedicated to incident management. The absence of this position has resulted in multiple employees reviewing incidents and investigations at different stages as well as inconsistent expectations of what investigations should cover.

The plan correcting the specific deficiency.

1. The facility determined that insufficient training was not the cause of the identified staff member not following Client #1's plan. The identified staff member received in person training by the Attendant Counselor (AC) 3 and had an opportunity to seek clarifications on what the care plan required. The identified staff member had been observed following Client #1's care plan on cottage. The AC Manager has also conducted observations of other staff members application of the resident's care plan, both on and off cottage, and concluded staff members are accurately able to implement the requirements of the care plan.
   Person(s) Responsible: [redacted] ACM
   Completed by: 8-1-19
2. The facility has reviewed incident #15849 and is unable to determine the location of where Client #3 obtained the money. Client #3 was likely to have obtained the money from a number of possible locations.
3. Client #3's IDT has met on 7-18-19 and reviewed incident #15849. The IDT will develop a formal program to address Client #3's behavior of stealing, including teaching Client #3 the consequences of stealing.
   Person(s) Responsible: [redacted] (HPA)
   Completed 8-9-19
4. The facility investigation #02-5242019 has been updated to include how the facility determined the alleged perpetrator was Staff F and not another staff member with the initials "DA."
   Person(s) Responsible: [redacted] QAD
   Completed by: 8-2-19

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

5. A Position Description Form (PDF) for an Incident Management Coordinator has been developed and reviewed by Class and Compensation. This position will be responsible for reviewing and providing investigatory feedback for every incident that occurs on Lakeland Village ICF. This position will also be responsible for:
   a. Reviewing completed investigations to verify the investigation was thorough and addresses compliance with local work procedures, DDA Policy, and Codes of Federal Regulation for the ICF
   b. Verifies investigations identify and investigate the root cause of why the incident occurred,
   c. Verifies any discrepancies identified in an investigation are resolved,
   d. Necessary and required client protections were in place to prevent further potential abuse during the incident investigation process,
   e. Corrective Action Plans developed during investigations meet the needs of the residents identified,
   f. All corrective action plans identified are completed within identified timelines, and
   g. All investigations are completed within 5 days of incident occurrence.
   h. Provides immediate feedback and training to facility investigators for deficiencies identified during incident report and investigation reviews.

   Person(s) Responsible: [redacted] QAD
   Completed by: 7-25-19
6. The Quality Assurance Director initiated working with the Department of Social and Health Services to create a recruitment notice to attract qualified candidates for the position.
   Person(s) Responsible: [redacted] QAD
   Completed by: 7-26-19
7. Interviews will be conducted with all qualified candidates.
   Person(s) Responsible: [redacted] QAD
   Completed by: 8-15-19
8. The preferred candidate from the interview process will be properly vetted following DSHS standards and an offer will be made as applicable. Should an appropriate candidate not be revealed through these processes the Quality Assurance Director will work with DSHS Talent Management to reopen the recruitment notice.
   Person(s) Responsible: [redacted] QAD
   Completed by: 9-6-19

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

1. The Quality Assurance Department will continue regular reviews of a sample of incident reports and corresponding investigations to verify thoroughness and timeliness of investigations.
2. Once hired, the Incident Management Coordinator will review and provide guidance and feedback to all incident investigations that occur at Lakeland Village ICF. The feedback and guidance will be provided within in 1 business day of an incident occurring and throughout the investigative process to verify each investigation is thoroughly completed. This position will also be responsible for facilitating regularly scheduled meetings, at least quarterly, with incident management personnel to review systematic deficiencies or best practices.

The title of the person or persons responsible for implementing the acceptable plan of correction

[redacted] QAD

Dates when the corrective action will be completed.

Lakeland Village will accomplish the corrective actions by September 6th, 2019.

Tag number

W-155

CFR and title

§483.420(d)(3) STAFF TREATMENT OF CLIENTS

Specific language from CFR

The facility must prevent further potential abuse while the investigation is in progress.

Explain the process that lead to this deficiency.

The facility does not currently have an employee dedicated to incident management. The absence of this position has resulted in multiple employees reviewing incidents and investigations at different stages as well as inconsistent expectations of what investigations should cover.

The plan correcting the specific deficiency.

1. The identified alleged perpetrator was placed on an alternative work assignment away from residents on 6-25-19. The alleged perpetrator will remain on alternative assignment away from residents until the conclusion of all investigation processes including Washington State Patrol's.
2. The ICF PAT Director has received direction to verify that alleged perpetrators are placed on alternative assignment away from residents as soon as possible after incident occurrence.
   Person(s) Responsible: Connie Lambert-Eckel, Superintendent
   Completed by: 8-2-19

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

9. A Position Description Form (PDF) for an Incident Management Coordinator has been developed and reviewed by Class and Compensation. This position will be responsible for reviewing and providing investigatory feedback for every incident that occurs on Lakeland Village ICF. This position will also be responsible for:
   a. Reviewing completed investigations to verify the investigation was thorough and addresses compliance with local work procedures, DDA Policy, and Codes of Federal Regulation for the ICF
   b. Verifies investigations identify and investigate the root cause of why the incident occurred,
   c. Verifies any discrepancies identified in an investigation are resolved,
   d. Necessary and required client protections were in place to prevent further potential abuse during the incident investigation process,
   e. Corrective Action Plans developed during investigations meet the needs of the residents identified,
   f. All corrective action plans identified are completed within identified timelines, and
   g. All investigations are completed within 5 days of incident occurrence.
   h. Provides immediate feedback and training to facility investigators for deficiencies identified during incident report and investigation reviews.

   Person(s) Responsible: [redacted] QAD

Completed by: 7-25-19

10. The Quality Assurance Director initiated working with the Department of Social and Health Services to create a recruitment notice to attract qualified candidates for the position.
    Person(s) Responsible: [redacted] QAD
    Completed by: 7-26-19
11. Interviews will be conducted with all qualified candidates.
    Person(s) Responsible: [redacted] QAD
    Completed by: 8-15-19
12. The preferred candidate from the interview process will be properly vetted following DSHS standards and an offer will be made as applicable. Should an appropriate candidate not be revealed through these processes the Quality Assurance Director will work with DSHS Talent Management to reopen the recruitment notice.
    Person(s) Responsible: [redacted] QAD
    Completed by: 9-6-19

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

1. The Quality Assurance Department will continue regular reviews of a sample of incident reports and corresponding investigations to verify thoroughness and timeliness of investigations.
2. Once hired, the Incident Management Coordinator will review and provide guidance and feedback to all incident investigations that occur at Lakeland Village ICF. The feedback and guidance will be provided within in 1 business day of an incident occurring and throughout the investigative process to verify each investigation is thoroughly completed. This position will also be responsible for facilitating regularly scheduled meetings, at least quarterly, with incident management personnel to review systematic deficiencies or best practices.

The title of the person or persons responsible for implementing the acceptable plan of correction

[redacted] QAD

Dates when the corrective action will be completed.

Lakeland Village will accomplish the corrective actions by September 6th, 2019.

Tag number

W156

CFR and title

§483.420(d)(4) STAFF TREATMENT OF CLIENTS

Specific language from CFR

The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.

Explain the process that lead to this deficiency.

The facility does not currently have an employee dedicated to incident management. The absence of this position has resulted in multiple employees reviewing incidents and investigations at different stages as well as inconsistent expectations of what investigations should cover. This absence has also resulted in multiple personnel tracking the completion of incident investigations that are completed by Compliance and Investigations Manager (CIMs). The facility also operated under the expectation received from Washington State Patrol (WSP) to limit investigation scope until WSP completed investigations prior to making a facility determination.

The plan correcting the specific deficiency.

1. The investigation for incident #01-06242019 was completed by CIM investigator on 6-27-19 to the extent authorized by Washington State Patrol. The corresponding 16-202A "Plan of Correction" was completed by the Assistant Superintendent on 6-29-19.
   Person(s) Responsible: [redacted] QAD
   Completed by: 6-29-19

2. Facility investigators have received direction that they are required to report results of all investigations to the Superintendent or designee within 5 working days, regardless of outside investigations that may be simultaneously occurring.
   Person Responsible: [redacted]
   Completed by: 8-1-19

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

13. A Position Description Form (PDF) for an Incident Management Coordinator has been developed and reviewed by Class and Compensation. This position will be responsible for reviewing and providing investigatory feedback for every incident that occurs on Lakeland Village ICF. This position will also be responsible for:
    a. Reviewing completed investigations to verify the investigation was thorough and addresses compliance with local work procedures, DDA Policy, and Codes of Federal Regulation for the ICF
    b. Verifies investigations identify and investigate the root cause of why the incident occurred,
    c. Verifies any discrepancies identified in an investigation are resolved,
    d. Necessary and required client protections were in place to prevent further potential abuse during the incident investigation process,
    e. Corrective Action Plans developed during investigations meet the needs of the residents identified,
    f. All corrective action plans identified are completed within identified timelines, and
    g. All investigations are completed within 5 days of incident occurrence.
    h. Provides immediate feedback and training to facility investigators for deficiencies identified during incident report and investigation reviews.

    Person(s) Responsible: [redacted] QAD
    Completed by: 7-25-19
14. The Quality Assurance Director initiated working with the Department of Social and Health Services to create a recruitment notice to attract qualified candidates for the position.
    Person(s) Responsible: [redacted] QAD
    Completed by: 7-26-19
15. Interviews will be conducted with all qualified candidates.
    Person(s) Responsible: [redacted] QAD
    Completed by: 8-15-19
16. The preferred candidate from the interview process will be properly vetted following DSHS standards and an offer will be made as applicable. Should an appropriate candidate not be revealed through these processes the Quality Assurance Director will work with DSHS Talent Management to reopen the recruitment notice.
    Person(s) Responsible: [redacted] QAD
    Completed by: 9-6-19

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

1. The Quality Assurance Department will continue reviewing all incident reports and providing feedback to facility investigators as to what may need to be covered in the investigation based on scope and severity of the incident.
2. Once hired, the Incident Management Coordinator will review and provide guidance and feedback to all incident investigations that occur at Lakeland Village ICF. The feedback and guidance will be provided within in 1 business day of an incident occurring and throughout the investigative process to verify each investigation is thoroughly completed. This position will also be responsible for facilitating regularly scheduled meetings, at least quarterly, with incident management personnel to review systematic deficiencies and best practices. The Incident Management Coordinator will also provide additional direction, training and support to facility investigators during this meeting and throughout the incident investigation process.

The title of the person or persons responsible for implementing the acceptable plan of correction

[redacted] QAD

Dates when the corrective action will be completed.

Lakeland Village will accomplish the corrective actions by September 6th, 2019.

Tag number

W-227

CFR and title

§483.440(c)(4) INDIVIDUAL PROGRAM PLAN

Specific language from CFR

The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.

Explain the process that lead to this deficiency.

The recommendation stated in the investigation was not clearly relayed to the resident's IDT. This failure resulted in the IDT not fully assessing the resident's need identified in the investigation as well as a training objective that did not fully meet the identified need.

The plan correcting the specific deficiency.

On [redacted]19, the identified resident cited, Client #4, passed away.

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

17. A Position Description Form (PDF) for an Incident Management Coordinator has been developed and reviewed by Class and Compensation. This position will be responsible for reviewing and providing investigatory feedback for every incident that occurs on Lakeland Village ICF. This position will also be responsible for:
    a. Reviewing completed investigations to verify the investigation was thorough and addresses compliance with local work procedures, DDA Policy, and Codes of Federal Regulation for the ICF
    b. Verifies investigations identify and investigate the root cause of why the incident occurred,
    c. Verifies any discrepancies identified in an investigation are resolved,
    d. Necessary and required client protections were in place to prevent further potential abuse during the incident investigation process,
    e. Corrective Action Plans developed during investigations meet the needs of the residents identified,
    f. All corrective action plans identified are completed within identified timelines, and
    g. All investigations are completed within 5 days of incident occurrence.
    h. Provides immediate feedback and training to facility investigators for deficiencies identified during incident report and investigation reviews.

    Person(s) Responsible: Brendan Arkoosh, QAD
    Completed by: 7-25-19
18. The Quality Assurance Director initiated working with the Department of Social and Health Services to create a recruitment notice to attract qualified candidates for the position.
    Person(s) Responsible: [redacted]QAD
    Completed by: 7-26-19
19. Interviews will be conducted with all qualified candidates.
    Person(s) Responsible: [redacted]QAD
    Completed by: 8-15-19
20. The preferred candidate from the interview process will be properly vetted following DSHS standards and an offer will be made as applicable. Should an appropriate candidate not be revealed through these processes the Quality Assurance Director will work with DSHS Talent Management to reopen the recruitment notice.
    Person(s) Responsible: [redacted]QAD
    Completed by: 9-6-19

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

1. The Quality Assurance Department will continue regular reviews of a sample of incident reports and corresponding investigations to verify thoroughness and timeliness of investigations.
2. Once hired, the Incident Management Coordinator will review and provide guidance and feedback to all incident investigations that occur at Lakeland Village ICF. The feedback and guidance will be provided within in 1 business day of an incident occurring and throughout the investigative process to verify each investigation is thoroughly completed. This position will also be responsible for facilitating regularly

scheduled meetings, at least quarterly, with incident management personnel to review systematic deficiencies or best practices.

The title of the person or persons responsible for implementing the acceptable plan of correction

[redacted] QAD

Dates when the corrective action will be completed.

Lakeland Village will accomplish the corrective actions by September 6th, 2019.

Tag number

W-239

CFR and title

§483.440(c)(5)(vi) INDIVIDUAL PROGRAM PLAN

Specific language from CFR

Each written training program designed to implement the objectives in the individual program plan must specify provisions for the appropriate expression of behaviors and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.

Explain the process that lead to this deficiency.

The facilities previous practice allowed for Positive Behavior Support Plans (PBSPs) to be renewed on a timeline differing from the rest of the resident's Individual Program Plan. This process allowed for PBSPs to be reviewed during the resident's IPP renewal process, but did not promote IDT involvement in review and potential revisions to the plan as it was already implemented. This bifurcated process resulted in PBSPs potentially not addressing identified needs that may have been otherwise prioritized by the IDT to be addressed as well as did not promote other IDT members involvement in the development of the PBSP.

The plan correcting the specific deficiency.

1. Client #3's IDT has met on 7-18-19 and reviewed incident #15849. The IDT will develop a formal program to address Client #3's behavior of stealing, including teaching Client #3 the consequences of stealing.
   Person(s) Responsible: [redacted] (HPA)
   Completed 8-9-19

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. Psychology Associates and corresponding IDT members are reviewing each resident's Functional Assessment (FA) and Positive Behavior Support Plan (PBSP) to verify all identified maladaptive behaviors have associated interventions or recommended training programs to support the resident learn a behavior that is adaptive or appropriate.
   Person(s) Responsible: Psychology Associates and IDT Members
   Completed by: 8-13-19
2. Psychology Associates have been directed to begin renewing every resident's FA and PBSP to be in alignment with a residents IHP renewal process.
   Person(s) Responsible: [redacted] Developmental Disabilities Administrator 1
   Completed by: 7-17-19
3. IDT members have received direction to discuss identified needs in assessments provided, including the FA/PBSP. Each need will be prioritized and documented in the resident's IHP. Formal programs will be developed by the IDT as indicated from the prioritized list.
   Person(s) Responsible: Facility HPAs and IDT members
   Completed by: 7-17-19

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

1. The DDA Licensed Psychologist will review every resident's FA/PBSP to verify all maladaptive behaviors have associated interventions or recommended training programs prior to the program being implemented. Identified deficiencies will be immediately reported back to the psychology associate for corrections.
2. Habilitation Plan Administrators facilitate a review of the FA/PBSP with other members of the IDT. Any identified discrepancy or concern will be immediately communicated to the Psychology Associate.

HPAs will also verify the FA/PBSP is submitted to the HPA within the designated periods for an IHP renewal. The HPA will notify the Psychology Associate and their supervisor for any identified FA/PBSP not submitted within the designated periods.

The title of the person or persons responsible for implementing the acceptable plan of correction

[redacted], DDA 1

Dates when the corrective action will be completed.

Lakeland Village will accomplish the corrective actions by September 6th, 2019.